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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DIANA DEAN STEVENS** 1374 San Luis Avenue Los Osos, CA 93402 Registered Nurse License No. RN 403287 Nurse Practitioner Certification No. NP 17590 Respondent.	Case No. 2011-40 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1986, the Board of Registered Nursing issued Registered Nurse License Number RN 403287 to Diana Dean Stevens (Respondent Stevens). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2012, unless renewed.

3. On or about August 2, 2007, the Board of Registered Nursing issued Nurse Practitioner Certification No. NP 17590 to Diana Dean Stevens (Respondent Stevens). The Nurse

Practitioner Certification was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2012, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

5. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

9. Section 2725 of the Code states:

"(a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated

patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

"(b) The practice of nursing within the meaning of this chapter [the Nursing Practice Act] means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or

changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

. . .

10. Section 118, subdivision (b), of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

REGULATIONS

11. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

12. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

13. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

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"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

DEFINITIONS

14. **Ativan** - is the trade or brand name of Lorazepam. It is a Schedule IV, controlled substance, pursuant to Health and Safety Code Section 11057(d)(16) and is a dangerous drug pursuant to Business and Professional Code, Section 4022.

15. **Morphine/Morphine Sulfate** - is a Schedule II, controlled substance, pursuant to the Health and Safety Code Section 11055(b)(1)(M) and a dangerous drug pursuant to the Business and Professions Code 4022. MS Cotin, Msir, Oramorph SR and Kadian are brand names for Morphine Sulfate.

16. **"Pyxis"** is a computerized automated medication system which operates similarly to an automated teller machine at a bank. Mediations can be withdrawn from the Pyxis machines only by an authorized staff person using his or her own personalized access code. The Pyxis

machine makes a record of the medication and dose, date and time it was withdrawn, the user identification, and the patient for whom it was withdrawn.

FACTS COMMON TO ALL CAUSES FOR DISCIPLINE

17. The following facts are common to all causes for discipline in this matter:

A. At all times relevant herein, Respondent Diana Dean Stevens was employed as a registered nurse in the Intensive Care Unit (ICU) of Sierra Vista Regional Medical Center in San Luis Obispo, California (Medical Center).

B. At all times relevant herein, Susan Marie McDougall was employed as a registered nurse in the Sierra Vista Regional Medical Center in San Luis Obispo, California (Medical Center). On February 3 and 4, 2009, she was assigned to work in the surgical recovery room.

C. Patient Ruben N. (Patient) a 26 year old disabled resident of a skilled nursing facility, suffered respiratory and cardiac arrest on January 29, 2006. He was taken in a coma to Medical Center.

D. At Medical Center, he was diagnosed as having suffered irreversible brain damage, and was maintained on a respirator.

E. According to Medical Center records, Patient weighed 80 pounds at the time of his admission.

F. Physician's Orders:

1) Morphine - On February 1, 2006, Dr. Shultz wrote an order for Morphine, for severe pain, every 15 min IV.

2) Ativan - On February 1, 2006, Dr. Ryan wrote an order for Ativan, 2mg every 15 minutes, PRN for seizures. On February 3, 2006, Dr. Ryan wrote a second order for Ativan, 10 mg every 4 hours for lip smacking.

G. On or about February 2, 2006, Patient's mother gave consent for donation of his organs for transplant after cardiac death, to California Transplant Donor Network (CTDN).

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H. On or about February 3, 2006, Dr. Hootan Roozrokh traveled by air to Medical Center with a team from CTDN to procure Patient's organs for transplant. He arrived at approximately, 2210 hours.

I. Carla Albright, a registered nurse, was an organ harvest team coordinator from CTDN.

J. On or prior to February 2006, CTDN had provided an in- service training for Medical Center Staff regarding organ recovery. Respondent Stevens did not attend the training, though she received and reviewed a pamphlet and/or training handouts placed in her hospital mail box.

K. On February 3, 2006 at the beginning of her regular shift, at approximately 1900 hours, Respondent Stevens was assigned as the primary nurse to care for Patient by the ICU charge nurse. He was the only patient assigned to her that evening.

L. The following events then transpired in ICU:

TIME	**FEBRUARY 3, 2006**
1) 1930 hours	Respondent Stevens assessed Patient's neurological status and documented her assessment. (24 Hour Critical Care Flow Sheet).
2) Prior to 2132 hours	Carla Albright (organ harvest team coordinator) met with Respondent Stevens in the ICU near the beginning of Respondent's shift. Albright then requested that Stevens give Patient Morphine and Ativan. Respondent then administered both drugs twice, as detailed below, in compliance with Albright's request.
3) 2132-2154 hours	Per the ICU Pyxis report, the following medications were removed by Respondent Stevens for Patient from the ICU Pyxis: 10mg Morphine (at 2132 hours) 2mg Ativan (at 2132 hours) 2mg Ativan (at 2153 hours) 10 mg Morphine (at 2154 hours)
4) 2205 hours	**Administration of Medication** : Respondent Stevens administered (per Physician's Orders) 10 mg Morphine, and 2 mg Ativan.

	- Respondent Stevens noted, lip movement and focal seizures in connection with the administration of Ativan. (24 Hour Critical Care Flow Sheet). - However, Respondent Stevens observed no evidence that Patient was in severe pain.
5) Prior to 2230 hours (estimated)	Dr. Roozrokh, accompanied by Dr. Martinez arrived at ICU, and reviewed Patient's chart.
6) 2230 hours	**Administration of Medication**: Twenty-five minutes after administering 10 mg Morphine, and 2 mg Ativan; Respondent Stevens administered both drugs a second time. - Respondent Stevens did not recall observing any evidence of seizures in connection with the second administration of Ativan. - Respondent Stevens did not observe evidence that Patient was in severe pain.
7) 2300 hours (estimated)	Dr. Roozrokh then ordered 100 mg of Morphine and 40 mg of Ativan for Patient. He wrote and signed the Physician's Order in Respondent Stevens' presence.
8) 2307-2311 hours	Per Pyxis records, the following medications were removed by Respondent Stevens for Patient from the ICU Pyxis: 40 mg of Morphine (at 2307 hours), 60 mg of Morphine (at 2308 hours), 4 mg of Ativan (at 2310 hours), 20 mg of Ativan (at 2310 hours) 16 mg of Ativan (at 2311 hours) Respondent Stevens stored the medications in her pocket, pending Patient's move to the operating room.

M. Shortly before midnight (at approximately 23:10), Patient was transported to the Operating Room (OR). Respondent Stevens was instructed by the ICU charge nurse to accompany Patient to the OR in order to administer medication obtained from Pyxis. It took approximately 5-6 minutes to push Patient's bed from the ICU to the OR. Respondent Stevens did not observe evidence that Patient was in pain or any sign of anxiety during transport.

N. Carla Albright instructed Respondent Stevens to change into surgical scrubs, and she did so.

O. Carla Albright requested that Respondent Stevens give her (Albright) 2 of the vials of Morphine (10 mg per vial x 2) that she had brought from ICU and she did so.

P. After scrubbing and gowning, Respondent Stevens entered the OR. She observed that Albright, Dr, Martinez and Dr. Roozrokh, among others, were present in room, and that Dr. Roozrooh was removing what Respondent Stevens thought was a gastric tube from patient.

Q. Dr. Lubarsky, who was on-call for Patient's attending physician at Medical Center, arrived about 15 minutes after Respondent Stevens entered the OR.

R. The following events then transpired in the OR. Throughout these events, Respondent Stevens was physically positioned, in relation to other personnel and the Patient, so that she was unable to clearly observe the patient or see his electronic monitors:

TIME	FEBRUARY 4, 2006
1) 0007 hours (estimated)	**Administration of Medication**: Respondent Stevens was ordered by Carla Albright to give Patient "half of what you have." Respondent Stevens then administered to patient 50 mg of Morphine and 20 mg of Ativan intravenously. (Medication administration was not charted) Dr. Lubarsky then ordered the removal of the breathing tube and the tube was removed. Patient continued breathing on his own after the breathing tube was removed. Respondent Stevens observed no indications that Patient was in pain, anxious or having seizures.
2) 0017- 0020 hours (estimated)	10- 15 minutes after the breathing tube was removed, Patient was still breathing, and had a sinus rhythm (heartbeat). Dr. Roozrokh stated that he didn't feel a pulse and wanted to call a P.E.A. (Pulseless Electrical Activity.) Dr. Lubarsky examined Patient and reported that she felt a pulse.
3) 0017 – 0020 hours (estimated)	**Administration of Medication**: Dr. Roozrokh ordered Respondent Stevens to give the remainder of the Morphine (30 mg) and Ativan (20 mg) to Patient. Respondent did so. (Medication Administration was not charted)

	Respondent Stevens observed no indications that Patient was in pain, anxious or having seizures.
4) prior to 0020 hours	Dr. Roozrokh requested (verbally) that Respondent Stevens obtain the same amount of medicine he had ordered before. Respondent phoned the Medical Center nursing supervisor, and requested 100 mg of Morphine and 40 mg of Ativan. The supervisor delegated registered nurse Susan McDougall to bring the medications to the OR.
5) 0020-0026 hours	Per Medical Center Pyxis records, the following medications were removed by McDougall from various Pyxis machines: 10 mg of Morphine (at 0020 hours) 16 mg of Ativan (at 0020 hours) 90 mg of Morphine (not known) 16 mg of Ativan (at 0025 hours) 8 mg of Ativan (at 0026 hours) McDougall went to two areas of the hospital to find the large quantity of medication that had been requested. Because she was a floating nurse, she had access privileges at multiple Pyxis machines.
6) 0030 hours (estimated)	McDougall arrived at OR a short time (approximately 5 minutes) after Respondent Stevens requested additional medication, and delivered the vials (100 mg Morphine and 40 mg Ativan) to Respondent Stevens. No order for the medications was written at that time.
7) 0035 hours (estimated)	**Administration of Medication** Respondent Stevens drew 50 mg Morphine and 20 mg Ativan into syringes – then administered it to Patient intravenously ("i.v.push"). (Medication Administration was not charted) Respondent Stevens observed no indications that Patient was in pain, anxious or having seizures. Respondent Stevens observed that Patient was still breathing. Respondent Stevens heard Dr. Roozrokh express frustration, stating "This is why I don't like the D.C.D.'s (Donation after Cardiac Death)"
8) 0035-0040 hours (estimated)	**Administration of Medication** Dr. Roozrokh directed Respondent Stevens to administer the remaining medications. She did so, administering 50 mg Morphine and 20 mg Ativan to Patient intravenously ("i.v.push"). (Medication Administration was not charted)

	Respondent Stevens was not in a position to monitor vital signs, but observed that Patient continued to breathe on his own after this fourth administration of medication in the OR, 35 to 40 minutes after the breathing tube was removed.
9) 0045-0055 hours (estimated)	Carla Albright was on the telephone (in the OR) calling several people. Then Dr. Roozrokh took off his surgical gloves and talked on the telephone for several minutes. Respondent Stevens was administering drugs while these conversations took place. Dr. Roozrokh then said "it's over" or "it's off." Respondent Stevens asked him what he wanted to do with the remainder of the Ativan she was injecting. He said he did not care. Stevens continued to administer the last cc or half of a cc remaining in the syringe to Patient.
10) 0100 hours	Patient was then transferred from the OR back to ICU.

S. Before leaving the OR, Respondent Stevens asked Dr. Roozrokh to document the verbal order for medications. Dr. Roozrokh made notations in the chart which Respondent Stevens did not immediately review. She later observed that he had written "2/3/06, 12:50 a.m. in OR Morphine 50 mg IV and Ativan 20 mg IV." - accounting for only half of what he had verbally directed her to obtain. At approximately 0215, Respondent Stevens wrote below Dr. Roozrokh's notation: "as verbal order 50 mg Morphine and 20 mg Ativan" and signed her name.

T. Respondent Stevens administered a total of 200 mg Morphine and 44 mg Ativan to Patient in the approximately 6 hour period between the start of her shift and Patient's return to ICU at approximately 0100 hours. Patient received no additional medication between his return to ICU and the end of Respondent Stevens' shift.

U. Patient was still breathing on his own when Respondent Stevens' shift ended at 0730 hours.

V. Patient did not expire until approximately 8 hours after extubation, and no organs were recovered for transplant.

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W. Dr. Hooran Roozrokh was criminally prosecuted by San Luis Obispo County for acts alleged to have been undertaken to accelerate Patient's death during that 8 hours period, in order to recover organs for transplant. He was acquitted after jury trial.

X. On or about August 12, 2006, Respondent Stevens was questioned about giving medications without understanding the results, and stated that she did not need to know the effect of the medications on the patient. Further, when asked if she would have administered more medications, Respondent Stevens stated that she would have stopped giving medications when she ran out of medications.

Y. On or about June 7, 2006, registered nurse Susan McDougall stated that she was very uncomfortable with unusual amount of medication she was asked to take to the OR, but that she obtained and delivered the medication without questioning the orders.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

18. Respondent DIANA DEAN STEVENS is subject to disciplinary action under section 2761, subdivision (a)(1) on grounds of unprofessional conduct as defined in California Code of Regulations, Title 16, sections 1443 and 1443.5, in that Respondent, while on duty as a registered nurse during her normal working shift on or about February 3 and 4, 2006 at Sierra Valley Regional Medical Center (Medical Center) in San Luis Obispo, CA, was incompetent in providing nursing care for 26 year old Patient as follows:

A. Failed to meet standard(s) for competent performance set out in 16 C.C.R. § 1443.5 (2) as follows:

1. Failed to review the side effects and complications of medications given to Patient;
2. Failed to obtain adequate knowledge to care for a DCD (Donation after Cardiac Death) patient;
3. Failed to check medication orders from the MAR against the chart;
4. Gave medications to the patient outside the prescribed amounts for specific conditions;

5. Gave controlled medications without knowing the intended uses or making assessment(s) of the medications effects; and///

6. Gave controlled medications without a verbal or written order by a licensed physicians;

B. Failed to meet standard(s) for competent performance set out in 16 C.C.R.§ 1443.5 (6) in that she failed to question the unusual amounts of controlled substances she was ordered to administer.

C. Failed to meet standard(s) for competent performance when she failed to report to her supervisor the order to give to Patient unusually high amounts of controlled substances. (Business and Profession Code § 2725 (4)).

D. Respondent made no assessments of Patient after the initial assessment at appropriatly 1930. Respondent thus failed to provide ongoing patient assessments as defined in Business and Professions Code § 2725 (d) (also see 22 C.C.R. §70215 (a) (1)) and to document ongoing assessments with each administration of medication.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent DIANA DEAN STEVENS is subject to disciplinary action under section 2761, subdivision (a)(1) on grounds of unprofessional conduct as defined in California Code of Regulations, Title 16, section 1442, in that Respondent, while on duty as a registered nurse during her normal working shift on or about February 3 and 4, 2006 at Sierra Valley Regional Medical Center (Medical Center) in San Luis Obispo, CA, was grossly negligent due to her failure to provide nursing care as required for Patient as follows:

A. Respondent committed gross negligence by following multiple orders to administer unusually high doses of controlled medications to Patient without sufficient information to reasonably assess harm and/or potential harm to the patient's safety and well being. Respondent did not question or express concern about the unusually high doses. Respondent followed and continued to follow orders to administer unusually high doses of controlled medications (even in two instances when the orders were given by a non-physician

who was not a Medical Center employee) without sufficient regard for her own duty to act as the patient's advocate, and to protect the patient.

B. Respondent committed multiple acts constituting gross negligence by repeatedly administering unusually high doses of controlled medications to Patient without ongoing objective or subjective assessments of the patient, without determining the patient's reactions to the medications post-administration, and without documenting administered patient care.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

20. Respondent DIANA DEAN STEVENS is subject to disciplinary action under section 2761, subdivision (a) on grounds of unprofessional conduct, in that Respondent committed unprofessional conduct while on duty as a registered nurse during her normal working shift on or about February 3 and 4, 2006 at Sierra Valley Regional Medical Center (Medical Center) in San Luis Obispo, CA, and assigned to provided nursing care for 26 year old Patient by reason of the following:

A. Acts of incompetence and negligence described more fully in paragraphs 18 and 19 above.

B. Respondent engaged in unprofessional conduct in following orders from Carla Albright, a non-physician who was not a Medical Center employee, to administer medications to Patient, and to give to Albright two vials of Morphine that she had withdrawn from Pyxis for Patient.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 403287, issued to Diana Dean Stevens;

2. Revoking or suspending Nurse Practitioner Certificate Number NP 17590, issued to Diana Dean Stevens;

3. Ordering Diana Dean Stevens to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: 7/15/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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